General Assembly

Substitute Bill No. 5500

February Session, 2014

HB05500HS 032114

AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 17b-99 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(d) The Commissioner of Social Services, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider that participates as provider of services in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall conduct any such audit in accordance with the provisions of this subsection. For purposes of this subsection "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample of the universe from which the sample was drawn; "medical necessity" has the same meaning as provided in section 17b-259b; "provider" means a person, public agency, private agency or proprietary agency that is licensed, certified or otherwise approved by the commissioner to supply services authorized by the programs set forth in said chapters; and "universe" means a defined population of claims submitted by a provider during a specific time period.

(1) The Commissioner of Social Services, or any entity with which the commissioner contracts for the purpose of conducting an audit of a service provider pursuant to this subsection, shall have access during a provider audit only to information relevant to the audit, including, but not limited to, information concerning: (A) Services and goods provided and billed to the Medicaid program during the time period covered by the audit, (B) medical necessity of such services and goods provided, and (C) whether the provider billed responsible third parties for such services or goods provided. Nothing in this subsection shall be construed as authorizing access to any information that is confidential or prohibited from disclosure by law. Not less than thirty days prior to the commencement of any such audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall provide written notification of the audit to such provider, unless the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider makes a good faith determination that **[**(A)**]** the health or safety of a recipient of services is at risk**[**;**]** or **[**(B)**]** the provider is engaging in vendor fraud. A copy of the regulations established pursuant to subdivision (11) of this subsection shall be appended to such notification.

(2) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which providers shall be subject to audits, the Commissioner of Social Services shall first select providers with a higher compliance risk based on past audits or errors. To the extent reasonably feasible, the commissioner, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, shall limit extrapolation of underpayments or overpayments based on a clerical error to similar claims, including, but not limited to, claims billed under the same medical billing codes.

(3) A finding of overpayment or underpayment to a provider in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a provider for which rates are established pursuant to section 17b-340, shall not be based on extrapolated projections unless (A) there is a sustained or high level of payment error involving the provider, or (B) documented educational intervention has failed to correct the level of payment error. **[**, or (C) the value of the claims in aggregate exceeds one hundred fifty thousand dollars on an annual basis.**]**

(4) A provider, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit.

(5) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall produce a preliminary written report concerning any audit conducted pursuant to this subsection, and such preliminary report shall be provided to the provider that was the subject of the audit not later than sixty days after the conclusion of such audit.

(6) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall, following the issuance of the preliminary report pursuant to subdivision (5) of this subsection, hold an exit conference with any provider that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such provider may present evidence at such exit conference refuting findings in the

preliminary report.

(7) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the provider that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subdivision (6) of this subsection, unless the commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, agrees to a later date or there are other referrals or investigations pending concerning the provider.

(8) Any provider aggrieved by a decision contained in a final written report issued pursuant to subdivision (7) of this subsection may, not later than thirty days after the receipt of the final report, request, in writing, a review on all items of aggrievement. Such request shall contain a detailed written description of each specific item of aggrievement. The designee of the commissioner who presides over the review shall be impartial and shall not be an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with which the commissioner contracts for the purpose of conducting an audit of a service provider. Following review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision.

(9) A provider may appeal a final decision issued pursuant to subdivision (8) of this subsection to the Superior Court in accordance with the provisions of chapter 54.

(10) The provisions of this subsection shall not apply to any audit conducted by the Medicaid Fraud Control Unit established within the Office of the Chief State's Attorney.

(11) The commissioner shall adopt regulations, in accordance with

the provisions of chapter 54, to carry out the provisions of this subsection and to ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process. The commissioner shall provide free training to providers on how to enter claims to avoid clerical errors and shall post information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than October 1, 2014, the commissioner shall (A) convene a meeting with representatives of the dental profession concerning billing, record-keeping procedures and standards of such profession and any modifications in the auditing process concerning dental providers that may be necessary and federally permissible, and (B) ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, has on staff or consults with a medical or dental professional who is experienced in the treatment, billing and coding procedures used by the provider subject to audit during such audit.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	17b-99(d)

HS *Joint Favorable Subst.*